IPMS
ETHIOPIA

Toolkit for Conducting HIV Risk and AIDS Vulnerability Assessment at the Woreda Level

Prepared by Clare Bishop-Sambrook
(Gender and HIV/AIDS Adviser)

2007

በኢትዮጵያ ፌዴራላዊ ዴሞክራሲያዊ ሪፑብሊክ
የግብርናና ገጠር ልማት ሚኒስቴር
Federal Democratic Republic of Ethiopia
MINISTRY OF AGRICULTURE AND RURAL DEVELOPMENT

ILRI
INTERNATINAL LIVESTOCK RESEARCH INSTITUTE

Canadian International Development Agency
Agence canadienne de développement international

Contents

1. Introduction 1
1.1 The HIV/AIDS epidemic in rural Ethiopia 1
1.2 Rationale for the toolkit 2
1.3 Audience 2
1.4 Structure of the toolkit 2
2. Key HIV/AIDS Concepts 3
2.1 Nature of the disease 3
2.2 Main sources of risk of HIV infection 4
2.3 Stage of the disease in the community 5
2.4 Scale of the epidemic 6
3. Tools for HIV/AIDS Analysis 7
3.1 Data collection methods 7
3.2 Conducting the fieldwork 8
3.3 Discussing HIV/AIDS in the Community 8
3.4 Tools and Templates 9
Tool 1: Understanding the External Environment 9
Tool 2: Identifying Bridging Populations 11
Tool 3: Understanding the Internal Environment 13
Tool 4: Changes in Household Composition and Size 15
Tool 5: Changes in Livelihood Activities and Outcomes 17
Tool 6: Community Response to HIV/AIDS 19
Tool 7: Indicators of Community's Possible Vulnerability to Impacts of AIDS 21
Tool 8: Summary of Risks and Vulnerabilities 23
Tool 9: Stage of Disease in Community 25
Tool 10: Activity Perspective 27
4. Opportunities for Integrating a HIV/AIDS Perspective into Market-led Agricultural Development 29
4.1 Responding to the epidemic 29
4.2 HIV/AIDS mainstreaming opportunities through market-led development 30
4.3 Partnerships and linkages for implementation 31
4.4 HIV/AIDS action planning matrix 31
Resource Materials 33
Annex 1: Example of Woreda HIV/AIDS Fact Sheet: Dale, SNNPR 34

1. Introduction

1.1 The HIV/AIDS epidemic in rural Ethiopia

The agricultural sector plays a central role in the Ethiopian economy and lies at the heart of government initiatives to accelerate nationwide economic growth. Even though rural HIV prevalence rates are lower than urban rates (1.8% and 10.1% respectively in 2005), the potential scale of the rural epidemic requires an urgent response (Box 1).

Box 1: Key facts

- There are about 1.3 million Ethiopians infected with HIV.
- An additional 350 people become infected every day.
- A similar number of people die every day from AIDS-related illnesses.
- AIDS accounts for 35% of young adult deaths (15-49 years old).
- Around 280,000 people require anti-retroviral treatment but only 35,000 were receiving antiretroviral treatment in mid-2006.
- Women are at least at 1.2 times greater risk of infection than men.

At the household level, the impact of the disease diverts attention and resources from productive activities to caring for the sick and surviving the aftermath of the death of key household members. If left unchecked, the disease changes the composition of rural communities and the priorities of farming households, thereby making many of the traditional production-oriented extension messages irrelevant. One significant aspect of the rural epidemic is the extent to which it may undermine efforts to improve agricultural productivity and to achieve market-led development.

The epidemic is already established in the rural areas of Ethiopia and although the HIV prevalence rate is relatively low at present, it is expected to continue to rise, at least in short term. Consequently, even if agriculturally-related development projects choose to do nothing about HIV/AIDS, the disease will inevitably have an impact on rural communities and their ability to participate in such initiatives. AIDS-affected households typically experience a loss of labour and skills, a reduction in the household asset base, and changes in household priorities to meet short term food needs rather than engage in potentially risky medium term investments. Government and partner institutions may also suffer if attrition rates rise among their workforce, thereby undermining investments in capacity building and institutional strengthening.

Moreover, if development efforts are successful in increasing productivity and farmers' engagement with the market, and thereby raising farm incomes, these actions may actually hasten the spread of the disease (since increases in mobility and increases in income, which may arise from improved marketing, are often cited as driving factors of the epidemic). Similarly, capacity building initiatives, such as training, study tours and farmer exchange programmes, may also increase the risk of exposure, if they involve overnight stays away from home. Hence it is essential that development agencies identify any likely increases in the risk of HIV infection associated with its activities and introduce remedial measures as necessary, as well as look for opportunities to contribute to addressing HIV/AIDS in the rural economy.

1.2 Rationale for the toolkit

This toolkit presents a range of tools that may be used for collecting and analysing field data to facilitate HIV/AIDS action planning in agricultural development projects. The reasons for conducting HIV risk and AIDS vulnerability assessment are fivefold:

- to increase the understanding of the sources of risk of HIV infection in the woreda;
- to increase the understanding of the impacts of AIDS to date and potential future sources of vulnerability;
- to identify possible inter-relationships between HIV/AIDS and the proposed activities;
- to identify opportunities in the project for promoting prevention, care and mitigation activities, as appropriate; and
- to contribute to the knowledge base about HIV/AIDS in the agricultural sector.

The materials have been prepared for, and field tested by, the CIDA-funded Improving Productivity and Market Successes Ethiopian Farmers Project based at ILRI, Addis Ababa.

1.3 Audience

The toolkit will be of use to organisations promoting rural development. The primary target groups will comprise woreda staff from the extension services of the Ministry of Agriculture and Rural Development such as the extension supervisors, woreda experts and development agents; health extension workers; staff from Women's Affairs and HIV/AIDS Prevention and Control Office (HAPCO); and teaching staff from the Agriculture TVET colleges and universities. The toolkit may also be of interest to NGOs and civil society organisations operating in rural areas.

1.4 Structure of the toolkit

The key concepts associated with analysing HIV/AIDS from a social development perspective are presented in section 2. The tools for data collection and analysis, with guidance notes on their use, are presented in section 3. The final section discusses how to interpret the findings and notes opportunities for HIV/AIDS mainstreaming through market-led development initiatives.

2. Key HIV/AIDS Concepts

This section describes some of the key concepts associated with analysing the HIV/AIDS epidemic from a social development perspective.

2.1 Nature of the disease

An individual passes through three stages between HIV infection and death and this process may spread over a period of between 8 and 10 years if anti-retroviral therapy is not available. The stages are described below:

- **HIV-infected but not yet affected:** After a person becomes infected with HIV, he or she can spend a number of years looking and feeling healthy and strong. This stage is very risky for the spread of the disease because an infected person can pass on the virus to others without knowing they are doing so, through unprotected sex or sharing unsterilised skin piercing instruments. Good nutrition and medical treatment can slow down the rate at which HIV weakens the immune system. This stage, without any symptoms, may last between six and eight years.

- **HIV-infected and affected:** The infected person starts becoming sick with opportunistic infections, such as tuberculosis, pneumonia, viral and fungal infections, which take advantage of the body's weakened immune system. As these illnesses become more frequent and persistent, the patient suffers from chronic fatigue. Medical treatments can prevent or cure some of the illnesses associated with AIDS. Household resources are diverted into patient care, involving not only the time of other household members to tend to the sick but also financial resources for medical treatment. The ability of someone suffering from AIDS-related illnesses to carry on with their normal lives depends on the extent to which physical strength and visual appearance is important. Once the person has full-blown AIDS, life expectancy without recourse to anti-retroviral therapy is two to three years.

- **AIDS-related death and impact on other household members:** Immediately following the death of an infected person, many households observe funeral and mourning rites. This can be a time-consuming and expensive process, further draining a household's limited resource base. If the deceased had a spouse, it is very likely that the spouse is also infected and it is only a matter of time before he or she becomes sick. A household may remain in a state of being infected and affected for several years. Many households struggle to survive the death of key household members, particularly in communities where the property inheritance system is weak or characterised by property grabbing by relatives of the deceased.

2.2 Main sources of risk of HIV infection

HIV-risky behaviour

- There are three main modes of behaviour which may result in individuals engaging in activities which expose them to the HIV virus;

- HIV-risky behaviour by choice, usually for pleasure: for example, multiple sexual partners, high alcohol or narcotic consumption which may lead to unprotected sex, and injecting drug use;

- HIV-risky behaviour by convention, culture, peer pressure or coercion: sexual norms, physically damaging sexual practices, widow inheritance, polygamy, rape, abduction, child sexual abuse and incest, early sexual debut, early marriage, inability to negotiate for safe sex due to unbalanced power relations, harmful traditional practices using unsterilised instruments (such as circumcision, female genital mutilation, milk tooth extraction, tonsillectomy) and a reluctance to abandon breast-feeding by HIV-positive mothers;

- HIV-risky behaviour by necessity: exchanging sexual favours for food, cash or preferential access to limited resources (such as male labour or food items for processing) and caring for the AIDS sick without due caution.

HIV-risky lifestyles and bridging populations

Some lifestyles place people at risk by presenting them with opportunities for unprotected sex with non-regular partners (Box 2). These activities usually take place away from home, often in urban areas where prevalence rates are usually higher than rural areas. The lack of social cohesion in this setting may encourage people to do things which they would not do if they were at home. Several of these lifestyle activities are associated with the generation of cash which increases the opportunity for new sexual liaisons.

These people often act as bridging populations, engaging in HIV-risky behaviour in high-risk environments away from home and then carrying the virus back into their homes and the community. Their sexual activities bridge high and low prevalence communities.

Box 2: People at risk of HIV infection due to lifestyle

- traders, merchants, transporters, foresters or fisherfolk who spend nights away from home in the course of their work;
- seasonal migrants and daily labourers seeking employment during the off-farm season;
- urban migrants seeking permanent employment, often leaving their families behind in the village;
- commercial sex workers and women working in bars and hotels;
- secondary school and college students living away from home during term time;
- extension workers, development agents, health personnel and teachers living in rural communities away from their families.

Changes in the sources of risk during an individual's life and according to gender

The potential source of infection varies by age (Box 3) and sex of the household member. Women and girls are among the high-risk group, often due to events beyond their control. For each sexual encounter, they are more biologically vulnerable to infection than men. They are also more socially vulnerable due to discriminatory social and cultural practices. In many communities women have lower rates of literacy than men, leave school earlier than boys, have limited access to sources of information, and have little opportunity to participate in decision making.

Due their weak social position and the dominance of men, women are either unaware or unable to insist on condom use and negotiate for safe sex. Gender inequalities also affect the ability of women to disclose their HIV status and utilise treatment and care services. They are also disadvantaged with regard to using and controlling economic resources in the household, and their lack of economic independence makes them more likely to engage in survival sex.

Box 3: Principal sources of transmissions by age

- Adults: unprotected sex with an infected person
- Youth: sexual contact or harmful traditional practices, such as circumcision, using unsterilised infected implements
- Children and infants: traditional practices
- Infants: Mother to Child Transmission (MTCT)

2.3 Stage of the disease in the community

Communities may pass through various stages of the epidemic, as the presence of the disease becomes evident. Identifying the stage of the epidemic at community level is complicated by the fact that, at any one time, different households in a community are at different stages of the epidemic.

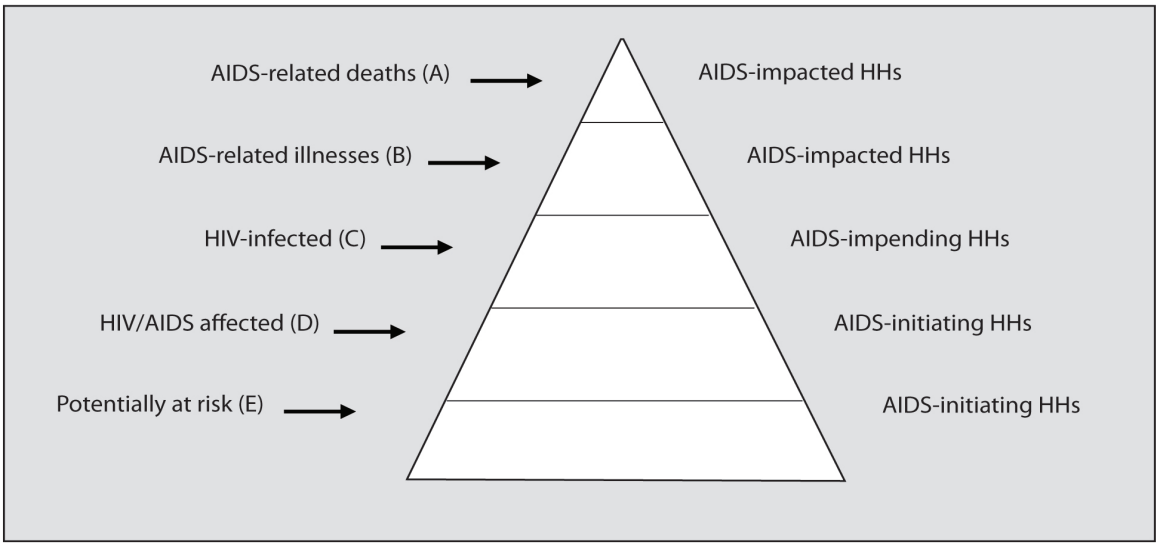
The six stages outlined below may span several years if not decades.

- AIDS-initiating: HIV/AIDS is almost non-existent with very low prevalence rates but any community is always potentially at risk from infection, especially if members of the community interact with high risk environments and, once infected, act as bridging populations to the home community;
- AIDS-impending: people are infected with HIV but are not showing any symptoms of AIDS-related illnesses; hence the presence of the disease is largely unknown;
- AIDS-impacted but ignorant: people are ill with AIDS-related illnesses but their illness is misdiagnosed due to a lack of knowledge about the disease;
- AIDS-impacted but denied: people are dying from AIDS-related illnesses but the community denies its presence and try to ignore it;
- AIDS-impacted and acknowledged: infected and affected households are present in the community and the disease is acknowledged as the cause of their plight;
- AIDS-recovering: HIV prevalence rates are declining but the community remains heavily AIDS-impacted due to the time lag between infection, illness and death;

2.4 Scale of the epidemic

The scale of the epidemic presents a serious challenge to extension work even if prevalence rates are relatively low (Diagram 1). Once AIDS-impacted households in a community start experiencing AIDS-related deaths (A) and illnesses (B), this is only the tip of the problem. It is likely that a much larger group is already *infected* with HIV but is not yet showing any symptoms (C). Many other households are also *affected* by the diversion of household resources to care for the sick or by fostering orphans (D). Ultimately the whole community is at risk of infection (E).

Diagram 1: HIV/AIDS Pyramid

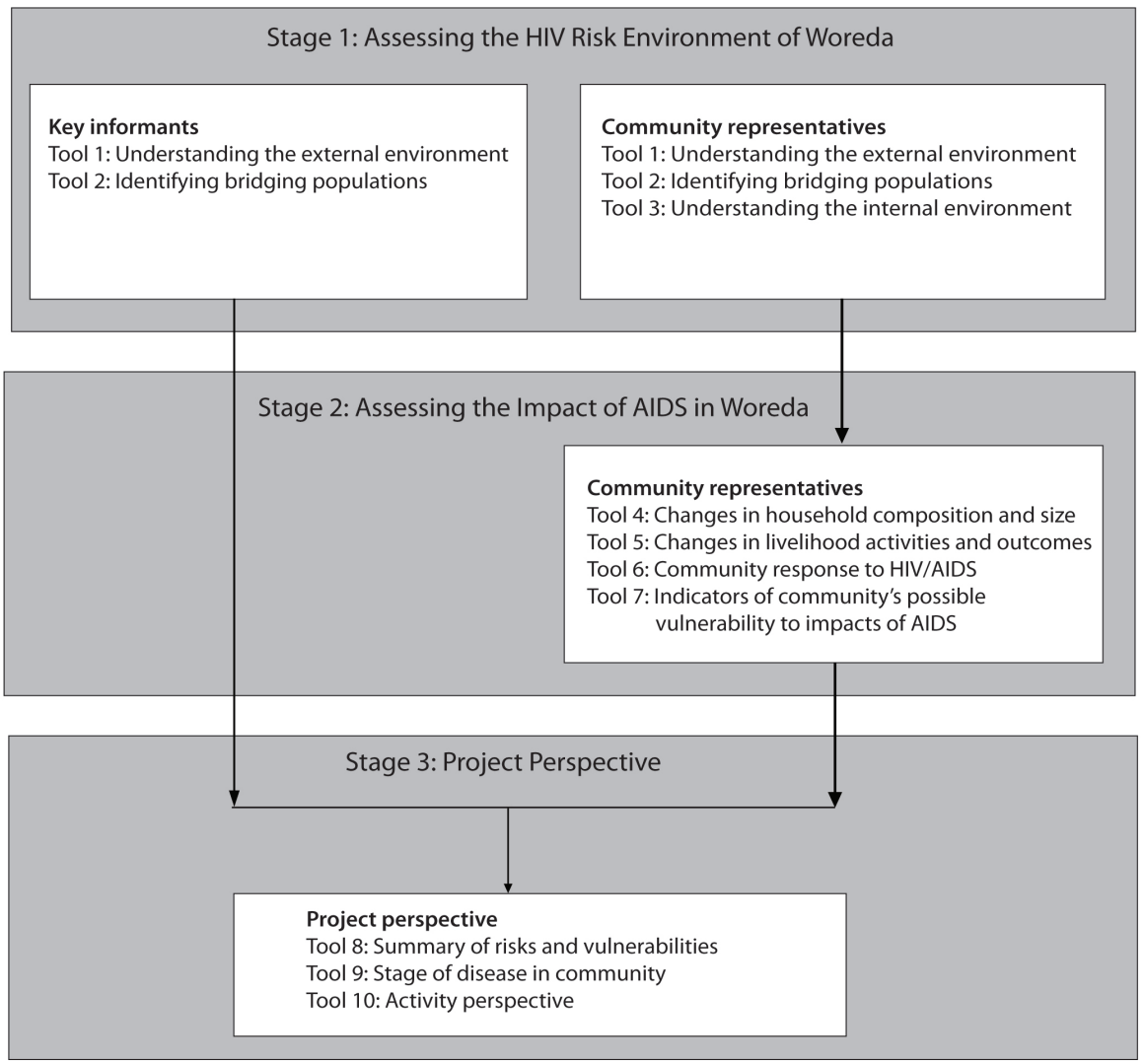


3. Tools for HIV/AIDS Analysis

3.1 Data collection methods

Ten tools are described below which can be used to gather data about the dynamics of HIV/AIDS at the woreda level. They are presented in three stages: first, to assess the HIV risk environment in the woreda; second, to assess the impacts of AIDS to date in the woreda; and third, to draw out the implications for project design and implementation (Diagram 2).

Diagram 2: HIV/AIDS assessment data collection methods



Tools 1 and 2 are used with key informants who know the woreda well, such as the HAPCO facilitator, staff from the Rural Development Department and health workers. They are also used with representatives from selected communities within the woreda. Tools 3 through to 7 are also used at the community level. It may be appropriate to meet with women and men separately in order to discuss some of the issues associated with HIV/AIDS. Tools 8, 9 and 10 are used by the project staff to reflect on the findings and their implications for proposed activities.

3.2 Conducting the fieldwork

The fieldwork should be conducted in a participatory manner, asking open-ended questions when appropriate and recording the answers as fully as possible. The tools are used as checklists; it is essential that they are adapted to be relevant to the local context, and to reflect the interest and priorities of the organisation undertaking the study. Meeting women, men and youth in separate groups often generates the broadest range of views and opinions. If possible, at least one or two women should be included in the study team, such as the home agents, women development agents or staff from Women's Affairs Desk in the Office of Agriculture and Rural Development (OoARD) or Women's Affairs Offices in order to enable women members of the community to feel more at ease and to express themselves more freely.

3.3 Discussing HIV/AIDS in the Community

Although many people are familiar with mobilising communities and their representatives to participate in meetings, the topic of HIV/AIDS is very sensitive and may require different approaches, depending on the stage of the disease in the community and how the community has responded to date. Stigma and discrimination often surrounds HIV/AIDS due to misunderstandings and misconceptions about the sources of infection, in particular its association with immoral behaviour.

It is easier to discuss HIV/AIDS in communities which already acknowledge the full reality of AIDS and are actively trying to cope with its impacts, than in communities which are in a state of denial and discriminate against people living with HIV/AIDS (PLWHA) and their families. Stigma also makes it difficult to reach the more vulnerable groups since targeting may draw more attention to their plight. Infected people often try and hide their status for fear of discrimination and, once the symptoms become apparent, many isolate themselves and withdraw from public space. Efforts should be made to minimise stigma and discrimination during the fieldwork (Box 4).

Box 4: Tips on dealing with stigma and discrimination during fieldwork

- Be tactful and sensitive to PLWHA and their families
- Avoid language or behaviour which may offend or hurt them
- Avoid stigmatising or discriminating actions or language with others
- Include PLWHA and their families in community discussions
- Ask local HIV/AIDS specialists to assist with the community meeting
- Increase community understanding about the basic facts of the disease

3.4 Tools and Templates

The 10 tools are described on the following pages, outlining the purpose of the tool, the composition of the interview group and a list of key questions, which may be adapted as necessary. A template is included for each tool to record the key information. At this stage it is important to record information in as much detail as possible; if it is summarised too quickly, its loses the richness of capturing the voices and perspectives from the field.

Tool 1: Understanding the External Environment

Purpose of tool: to identify the potential sources of risk of HIV of infection in the context of the woreda.

Interview group: This tool is used, together with tool 2, with two separate groups. The first group comprises key informants at woreda level including the HAPCO facilitator, staff from the Agricultural and Rural Development Department, Health Department, Women's Affairs Department and health workers. The second group comprises representatives from different groups in the community, such as farmers' groups, women's associations, youth associations and religious groups. In both groups, ensure a balance of women and men, and different age groups.

Questions

Ask the group to answer the following questions with reference to the map:

1. Draw a sketch map setting out the major towns, market places, health centres, hospitals, schools, trading centres, administration, water points, forests, places of work etc which are visited by the community.
2. Identify areas that are considered be hotspots for exposure to risk of HIV infection.
3. Examine the reasons why these areas are particularly HIV-risky environments: is it due to data on HIV prevalence rates from VCT centres etc; observed behaviour which is potentially risky; high rates of illness and death among adults showing AIDS-related symptoms?

Data collection sheet overleaf

Template 1: Understanding the external environment

Location:	Group: women men

HIV-risky hotspots in *woreda*	Reasons for assessment as HIV-risky environment

Tool 2: Identifying Bridging Populations

Purpose of tool: to identify potential bridging populations linking rural populations with the external environment.

Interview group: This tool is used, together with tool 1, with two separate groups. The first group comprises key informants at woreda level including the HAPCO facilitator, staff from the Agricultural and Rural Development Department, Health Department, Women's Affairs Department and health workers. The second group comprises representatives from different groups in the community, such as farmers' groups, women's associations, youth associations, and religious groups. In both groups, ensure a balance of women and men, and different age groups.

Questions

Ask the group to answer the following questions with reference to the map:

1. **Movement from community into the external environment:** Identify interactions between members of the community and the external environment (indicate on the map):
   - who travels outside the community? (women, men, youth, elderly, children)
   - where do they go?
   - when do they go? (daily, weekly, dry/wet season, harvest, hungry season etc)
   - why do they go? (to buy, sell, recreation, education, health, collect water/wood, earn money, migration for employment, fodder for livestock etc)
   - how long do they stay? (less than one day, overnight, several nights, several weeks etc)
   - where do they stay? (with friends, relatives, rented accommodation, hostel etc)
   - what do they do that might result in unprotected sex?

2. **Movement from external environment into the community:** Identify any movement of people from the external environment into rural communities (indicate on the map):
   - who comes to the community? (women, men, youth, elderly, children)
   - when do they come? (daily, weekly, dry/wet season, harvest, hungry season etc)
   - why do they come? (to buy, sell, recreation, education, health, administration, collect water/wood etc)
   - where do they come from?
   - how long do they stay? (less than one day, overnight, several nights, several weeks etc)
   - where do they stay? (with friends, relatives, rented accommodation, hostel etc)
   - what do they do that might result in unprotected sex?

3. Note what activities are currently taking place to reduce the risk of infection in the woreda.
4. Identify what other actions are required to reduce the risk of infection from the external environment.

Data collection sheet overleaf

Template 2: Identifying bridging populations

Location:	Group: women men

Potential bridging populations	**Reasons** (where do they go? when to they go? why do they go? how long do they stay? where do they stay? what do they do that might result in unprotected sex?)
FROM COMMUNITY TO EXTERNAL ENVIRONMENT	
FROM EXTERNAL ENVIRONMENT TO COMMUNITY	
ACTIVITIES TO REDUCE RISK OF INFECTION	
Ongoing	
Required	

Tool 3: Understanding the Internal Environment

Purpose of tool: to identify the potential sources of risk of HIV of infection within the community.

Interview group: representatives from different groups in the community, such as farmers' groups, women's associations, youth associations, and religious groups. Ensure a balance of women and men, and different age groups.

Questions

Ask the group to answer the following questions with reference to the map:

1. On a sketch map of the community identify the main places in the community where people meet (market place, bars, hotels, fishing beach, homes, school, water points, woods, neighbours etc).

2. ***Movement within the community:*** identify interactions between members of community (indicate on the map):
   - who visits these different locations? (women, men, youth, elderly, children)
   - when to they go? (daily, weekly, dry/wet season, harvest, hungry season etc)
   - why do they go? (buy, sell, recreation, education, health, collect water/wood etc)
   - how long do they stay? (less than one day, overnight, several nights, several weeks etc)
   - where do they stay? (with friends, relatives, rented accommodation, hostel etc)
   - what do they do that might result in unprotected sex?

3. **Other HIV-risky behaviour:** Is there anything that the community does which increases the likelihood of HIV infection?
   - what is the event? (for example, dances, weddings, rape, abduction, circumcision, widow inheritance, seasonal practices)
   - who is at risk?
   - why does this practice occur?

4. **Infrastructure:** where are the following services available (nearest):
   - access to information on HIV/AIDS and sexually transmitted diseases (STIs)?
   - access to condoms and cost?
   - voluntary counselling testing (VCT) centre?
   - treatment for STIs?

5. What **vision** do the youth have for their future?

Data collection sheet overleaf

Template 3: Understanding the internal environment

Location:	Group: women men

Groups at risk within community	**Reasons**	
MOVEMENT WITHIN THE COMMUNITY (where do they go? when to they go? why do they go? how long do they stay? where do they stay? what do they do that might result in unprotected sex?)		
EVENTS, CULTURAL AND TRADITIONAL NORMS (what is the event? who is at risk? why does this practice occur?)		
Events	Who is at risk	Why?
INFRASTRUCTURE (nearest service available?)		
Access to information on HIV/ AIDS and STIs		
Access to condoms		
VCT centre		
Treatment for STIs		
Youths' vision for the future		

Tool 4: Changes in Household Composition and Size

Purpose of tool: to identify the distribution of households in the community between the main household types, and changes in the distribution during the last 10 years (with special reference to potentially vulnerable households), as well as changes in household size.

Interview group: representatives from different groups in the community, such as farmers' groups, women's associations, youth associations, and religious groups. Ensure a balance of women and men, and different age groups.

Questions

1. Identify the different types of household that are present in the community. For example, they may include:
   - Married households – monogamous
   - Married households – polygamous
   - Female-headed households (FHHs)
   - Single male-headed households (SMHHs)
   - Grandparent-headed households (GHHs)
   - Orphan-headed households (OHHs)
   - Others (specify)
2. Note the total number of households in the community (approximately). Define a household to be the unit in which people eat together in the evening.
3. Use proportional piling to determine the distribution of total households across the household types. Take a large number of seeds (100 or 200) and explain that this represents the total number of households in the community. Ask for a volunteer to distribute the seeds between the different household types. Give other people a chance to adjust the distribution until all are happy. Add up the number of seeds in each group and divide by the total number of seeds in order to calculate the present percentage distribution.
4. Repeat the exercise in order to determine the distribution five years ago and ten years ago.
5. Movement between groups: Have there been any movements between the household types?
   - Which household types are expanding in number?
   - Which household types are contracting in number?
   - What are the reasons underlying these changes?
6. Changes in household size: Have there been any changes in the number of people living in a household, by household type, during the last five years?
   - Which household types are expanding in size?
   - Which household types are contracting in size?
   - What are the reasons underlying these changes?

Data collection sheet overleaf

Template 4: Changes in household composition and size

Location:	Group: women	Men

	Household type *					
	Married - monogamous	**Married - polygamous**	**Female-headed HHs**	**Single male-headed MHHs**	**Orphan-headed HHs**	**Grand parent-headed HHs**
HOUSEHOLD DISTRIBUTION						
Distribution at present (total = 100%)						
Distribution 5 years ago (total = 100%)						
Distribution 10 years ago (total = 100%)						
Reasons for growth/ decline in number of households						
CHANGES IN HOUSEHOLD SIZE						
Average number of people per household today						
Average number of people per household two years ago						
Average number of people per household five years ago						
Reasons for change in household size						

** The households listed here are for illustrative purposes*

Tool 5: Changes in Livelihood Activities and Outcomes

Purpose of tool: to identify changes in farm and non-farm livelihood activities and their outcomes at household level during the last five years.

Interview group: representatives from different groups in the community, such as farmers' groups, women's associations, youth associations, and religious groups. Ensure a balance of women and men, and different age groups.

Questions

1. During the last five years, have any changes taken place in farming activities? If so, what changes have taken place, what are the reasons for these changes and which types of household have been affected by these changes?

    - Area cultivated per household
    - Use of irrigated land
    - Fallow land per household
    - Crop enterprises
    - Livestock enterprises
    - Division of labour between household members
    - Use of reciprocal labour groups/labour sharing
    - Use of share cropping
    - Use of labour saving technologies and practices

2. During the last five years, have any changes taken place in non-farming activities (for example, fishing practices, forestry, soil and water conservation, income generating activities). If so, what changes have taken place, what are the reasons for these changes and which types of household have been affected by these changes?

3. During the last five years, have any other changes have taken place in rural livelihoods? If so, what changes have taken place, what are the reasons for these changes and which types of household have been affected by these changes?

    - Division of labour between household members
    - Household asset base
    - Household savings
    - Expenditure patterns
    - Use of labour saving technologies and practices
    - Composition of diet
    - Health of household members
    - Attendance at school
    - Contribution to communal labour activities in community
    - Burial traditions

Data collection sheet overleaf

Template 5: Changes in livelihood activities and outcomes during last five years

Location:	Group: women men

	Nature of change	Reasons for change	Household types affected
FARMING ACTIVITIES AT THE HOUSEHOLD LEVEL			
Area cultivated			
Use of irrigated land			
Fallow land			
Crops/trees grown			
Livestock reared			
Division of tasks between HH members			
Use of reciprocal labour groups/labour sharing			
Use of share cropping			
Use of labour saving technologies and practices			
NON-FARM ACTIVITIES AT THE HOUSEHOLD LEVEL *(eg fishing, forestry, trading, brewing, selling food)*			
OTHER CHANGES AT THE HOUSEHOLD LEVEL			
Division of HH tasks between HH members			
Household asset base			
Household savings			
Expenditure patterns			
Use of labour saving technologies and practices			
Composition of diet			
Health of household members			
Attendance at school			
Contribution to communal labour activities in community			
Changes in burial traditions			

Tool 6: Community Response to HIV/AIDS

Purpose of tool: to identify how the community has responded to the HIV/AIDS epidemic to date and further actions required.

Interview group: representatives from different groups in the community, such as farmers' groups, women's associations, youth associations, and religious groups. Ensure a balance of women and men, and different age groups.

Questions

1. Are there any activities taking place in the community to raise awareness about HIV/AIDS. If so, what activities, who is undertaking them and who is supporting them (by providing trainers, materials etc)?
2. Are there any activities taking place in the community to reduce the risk of HIV infection? If so, what activities, who is undertaking them and who is supporting them (by providing trainers, materials etc)?
3. Are any activities taking place at *woreda* level to reduce the risk of HIV infection? If so, what activities, who is undertaking them and who is supporting them (by providing trainers, materials etc)?
4. Has the community noted any changes in high risk behaviour among certain groups in the community?
5. How does the community help people living with HIV/AIDS?
6. What are the traditional practices for treatment of people living with HIV/AIDS, if any?
7. Are there any activities taking place in the community to help households cope with the impacts of AIDS during sickness? If so, what activities, who is undertaking them and who is supporting them?
8. Are there any activities taking place in the community to help households cope with the impacts of AIDS following death? If so, what activities, who is undertaking them and who is supporting them?
9. What happens to AIDS orphans living in the community?
10. What other community responses could assist in reducing the risk of HIV infection?
11. What other community responses could assist in reducing vulnerability to the impact of AIDS?

Data collection sheet overleaf

Template 6: Community response to HIV/AIDS

Location:	Group: women	men

Indicators	Description of community response
HIV/AIDS awareness raising activities? (what activities, by whom, target group, support?)	
Activities to reduce risk of HIV infection? (what activities, by whom, target group, support?)	
Any changes in high risk behaviour observed?	
Activities to assist people living with HIV/AIDS? (what activities, by whom, support?)	
Traditional practices for treatment of people living with HIV/AIDS	
Activities to assist households cope with the impact of AIDS during sickness? (what activities, by whom, target group, support?)	
Activities to assist households cope with the impact of AIDS following death? (what activities, by whom, target group, support?)	
AIDS orphans in community?	
Other community responses to reduce risk of HIV infection?	
Other community responses to reduce vulnerability to impact of AIDS?	

Tool 7: Indicators of Community's Possible Vulnerability to Impacts of AIDS

Purpose of tool: in communities where the impact of AIDS to date has been low, to identify the potential vulnerability to the impact of AIDS, as a result of the way in which households deal with labour shortages, food shortages, illness and death.

Interview group: representatives from different groups in the community, such as farmers' groups, women's associations, youth associations, and religious groups. Ensure a balance of women and men, and different age groups.

Questions

Discuss the following questions with reference to different types of household:

1. How do households cope when an adult member (husband or wife) is ill for a long time or dies? How do these responses vary depending on whether it is a man or a woman who is ill or dies?
2. If an adult member of a household is ill for a long time or dies, how do households raise cash, if required?
3. What happens to the household assets (including access to land) when a man dies?
4. What happens to the household assets (including access to land) when both parents die?
5. What happens to the surviving household members after the death of a key adult?
6. How do households generally cope with shortages of labour and farm power?
7. How do households generally cope with food shortages?
8. How do neighbours or the community help households cope with any long term sickness, death and post death?

Data collection sheet overleaf

Template 7: Indicators of community's possible vulnerability to impacts of AIDS

Location:	Group: women men

Indicators	Response according to wealth of household		
	Rich	Middle wealth	Poor
How do households cope with long term illness or death of wife?			
How do households cope with long term illness or death of husband?			
How raise cash during long term illness or death?			
Transfer of assets when man dies			
Transfer of assets when both parents die			
What happens to surviving household members?	Widow: Widower: Orphans:	Widow: Widower: Orphans:	Widow: Widower: Orphans:
How respond to labour or farm power shortages?			
How respond to food shortages?			
How do neighbours or community assist with any long term sickness or death?			

Tool 8: Summary of Risks and Vulnerabilities

Purpose of tool: to summarise the risks of HIV infection and vulnerability to the impact of AIDS at the individual, household and community level and to identify opportunities to reduce these risks or vulnerabilities, by drawing on information gathered in Tools 1 to 6.

Group: survey team.

Questions

1. Summarise sources of risk of HIV infection at individual, household and community levels (Tools 1, 2 and 3).
2. Identify opportunities to reduce the risk of infection at the individual, household and community level (Tools 2, 3 and 6).
3. Summarise the sources of vulnerability to the impact of AIDS at individual, household and community levels (Tools 4 to 7).
4. Identify opportunities to reduce the vulnerability to the impacts of AIDS at individual, household and community levels Tools 6 and 7).

Data collection sheet overleaf

This information may be presented in the form of a woreda HIV/AIDS fact sheet; see Annex 1 for an example.

Template 8: Summary of risks and vulnerabilities

Location:	Group: women men

Level	Sources of risk of infection	Opportunities to reduce risk of infection
Individual		
Household		
Community		

Level	Sources of vulnerability to impact of AIDS	Opportunities to reduce vulnerability to impacts
Individual		
Household		
Community		

Tool 9: Stage of Disease in Community

Purpose of tool: to draw on the information collected from the community in order to identify the stage of the disease in the community.

Group: survey team.

Template 9: Stage of disease in community

Location:

Variable	Observations
Identification of sources of risk of infection: ▪ hotspots (Tools 1 and 3) ▪ bridging populations (Tools 2 and 3)	
Evidence of behaviour change towards potentially HIV-risky activities • youth vision (Tool 2) • changes in traditional practices (Tool 2) • other behaviour changes (Tool 6)	
Change in composition of community (Tool 4) • growth in HH types • decline in HH types • changes in HH size • reasons • AIDS orphans (Tool 6)	
Changes in livelihoods (Tool 5) • activities indicating shortage of labour • activities indicating shortage of cash • activities indicating life is becoming more difficult, community burdened by high death rate	
Community response to address HIV/AIDS (Tool 6) • awareness raising • support organisations • summary: not aware, denial and despair, acknowledgement and pro-active coping	

Priority target groups for HIV awareness raising and AIDS support (Tools 7 and 8) • households • individuals • economic activities	

Ranking of community	**Reasons**
Stage of disease: • AIDS-initiating • AIDS-impending • AIDS-impacted	

Tool 10: Activity Perspective

Purpose of tool: to analyse the potential implications of promoting agricultural development from a HIV/AIDS perspective and to identify ways in which activities may be used to maximise the positive benefits and minimise the negative ones.

Group: survey team.

Template 10A: Opportunities to reduce risk of HIV infection associated with market-led agricultural growth

Activity	Potential HIV risk	Opportunities to reduce risk
Farmer training/ exchange visits/ study tours and capacity building with partners		
Extension services have more contact with farmers		
Influx of seasonal labourers to work on farms to assist with labour peaks		
Increase in productivity		
Increase in market engagement		
Increase in visits to processing plants (mills, hulleries, polishers) by farmers		
Increased trading and transport of produce out of rural community		
Increase in income, seasonal income flows		
More trading in local market		
Status of women in marketing		
Other		

Template 10B: Opportunities to work in AIDS-impacted communities in context of agricultural market-led growth initiatives

Impacts of AIDS at household level	Implications for market-led initiatives	Opportunities to reduce impacts
Reduced labour productivity/ energy during sickness (farmer, family members, skilled hired labour, casual labour, labour group members) and loss of labour (time) (during sickness, death, caring for sick)		
Self exclusion when sick (farmer, family members, skilled hired labour, casual labour, labour group members)		
Loss of skills (farmer, family members, skilled hired labour, casual labour, labour group members)		
Loss of social capital		
Reduced financial resources (sale of assets to raise money for medication, funeral; less income)		
Insecure asset base (particularly for FHHs)		
Changed household priorities		
Loss of institutional capacity		

Note: The impact of AIDS illnesses and death on market-led initiatives varies according to who is sick/ dies; household wealth; farming systems; labour and skills requirements; and local support systems.

4. Opportunities for Integrating a HIV/AIDS Perspective into Market-led Agricultural Development

This section presents opportunities for HIV/AIDS mainstreaming that may be relevant to consider when designing field activities, such as training, field visits or technology development, and concludes with an action planning matrix.

4.1 Responding to the epidemic

The stage of HIV/AIDS epidemic in community influences the principal thrust of activities. In communities where few members of the community are infected, most of the emphasis is on increasing awareness and understanding about the disease with a view to reducing the risk of infection (Table 1). In communities where a significant proportion of the population are already infected but not yet sick with the disease (AIDS-impending), priority is given to preparing households to reduce the impacts of AIDS. Finally, in AIDS-impacted communities, attention is focused on providing care and support to PLWHA and their families and adjusting to the impacts of the disease. However, in any community, it is likely that all stages of the disease are present in different households, so all activities are relevant, to a lesser or greater extent.

Table 1: Principal Focus of HIV/AIDS Activities According to Stage of Epidemic

Stage of epidemic	Focus	Objectives
All stages	Reducing the risk of HIV infection	• Increase awareness and understanding of HIV/AIDS • Change behaviour and attitudes at individual and community levels • Reduce risky behaviour, lifestyles and environment • Encourage people to know their HIV status through VCT
AIDS-impending	Preparations to reduce vulnerability to impacts of AIDS	• Maintain and improve health and nutritional status, including access to anti-retrovirals when necessary • Secure asset base • Secure and diversify livelihoods • Record, store and share local knowledge
AIDS-impacted	Providing care and support for PLWHA and their families	• Maintain and improve health and nutritional status • Promote adherence to anti-retroviral therapy • Psycho-social support • Prevent infection of others
	Adapting to overcome impacts of AIDS	• Adapt livelihoods to new resource base with less labour, fewer assets, fewer skills, lower income • Care for orphans • Provide economic and social support for severely affected households

4.2 HIV/AIDS mainstreaming opportunities through market-led development

The activities listed below focus on opportunities for HIV/AIDS mainstreaming specifically in the context of market-led development initiatives.

Raise awareness and increase understanding about HIV/AIDS

- Use farmers associations, cooperatives and marketing groups as entry points for behaviour change communication activities, particularly targeting men and the youth.
- Target groups associated with agricultural production and marketing who are often overlooked by HIV/AIDS outreach activities (eg traders, store owners, transporters, middlemen, petty traders).
- Use market days to educate people about HIV/AIDS, including testimonies by people living with HIV/AIDS.
- Hold intensive awareness campaigns during seasons of high risk, such as harvesting and holidays.
- Identify innovative ways for reaching rural communities with HIV/AIDS messages (eg local cinemas).
- Integrate HIV/AIDS awareness training into all training courses, workshops, field visits etc.
- Facilitate access to relevant HIV/AIDS materials in woreda knowledge centre and farmer training centres (translate materials into local languages).
- Identify opportunities to reduce the stigma associated with the disease.

Reduce the risk of exposure to HIV infection

- Bring the input supply and marketing chain closer to farmers in order to reduce the need to travel and spend nights away from home (eg bulk purchasing, forward contracts, market information).
- Improve the modes of transport.
- Reduce delays at processing plants and distribution points by improving capacity/throughput of plant and improving the efficiency of handling procedures.
- Educate farmers and seasonal labourers to manage their earnings for the benefits of the family by saving, broadening their horizons and investing in their future.
- Strengthen women's position through economic empowerment.
- Make the marketing chain more women-friendly and secure.
- Reduce the wish to migrate from rural areas by increasing livelihood options, particularly for the youth.
- Minimise the risk associated with capacity building (reduce the number and duration of training courses held away from home, train couples (husband and wife), reduce overnight stays away).
- Improve living conditions in rural areas and minimise the need for development agents to live away from their families.

Reduce vulnerability to the impacts of AIDS

- Review the labour requirements of priority commodities and the likely future labour availability in AIDS-impacted communities.
- Ensure the proposed enterprise mix is sustainable even with depleted household resources.
- Identify income generating activities suitable for people living with HIV/AIDS.

- Promote income generating activities with modest capital and labour requirements for impacted households (target FHHs, single MHHs, orphans) with capability to participate in new non-farm livelihood opportunities.
- Overcome barriers to production and marketing faced by AIDS-infected and affected households (eg overcome labour constraints, reduce the labour burden of rural living, form groups to assist in transporting produce to market or processing, form marketing groups among petty traders).
- Develop market opportunities for crops and livestock suited to the resource base of infected and affected households (including the need to be near home to care for the sick).
- Use farmers' associations as an entry point for AIDS care and support for members (eg social fund for orphans).
- Promote crops and livestock contributing to balanced diets for people living with HIV/AIDS, especially those receiving anti-retrovirals with special nutritional requirements.
- Develop the farming skills of a wide group of farming households and labourers.
- Involve share cropping partners in market development initiatives.
- Work with microfinance institutions to provide access to emergency loans, promote voluntary savings and loans groups.

4.3 Partnerships and linkages for implementation

There are many organisations active in the HIV/AIDS response. It is important that these efforts are not duplicated and that opportunities are created for encouraging potential partners to co-plan, to work together, and to share materials and other resources.

Potential partners include:
- Agriculture: development agents, farmer training centres, OoARD
- Health: extension workers, health centres, VCT centres
- HAPCO: staff
- Others: Women's Affairs, associations (PLWHA, anti-AIDS clubs, mahibers, ekub, idirs), cooperatives, assistance for orphans and vulnerable children and PLWHAs, religious leaders

4.4 HIV/AIDS action planning matrix

The HIV/AIDS planning matrix overleaf identifies potential activities suitable for communities at different stages of the epidemic. The activities are set in context of their target groups and linked to potential implementing partners.

HIV/AIDS action planning matrix

Location:

Stage of epidemic	Focus	Target group	Activities	Potential partners
All stages	Reducing the risk of HIV infection through raising awareness and increasing understanding			
	Reducing risk of exposure to HIV infection			
AIDS-impending and AIDS-impacted	Reducing vulnerability to impacts of AIDS			

Resource Materials

Bishop-Sambrook C. (2004) Addressing HIV/AIDS through Agriculture and Natural Resource Sectors: A guide for extension workers, Rome: FAO (SEAGA Programme)
http://www.fao.org/sd/dim_pe1/docs/pe1_050103d1_en.pdf

FAO HIV/AIDS Programme
Pocketbook on integrating HIV/AIDS into food security and livelihoods projects
ftp://ftp.fao.org/docrep/fao/007/y5575e/y5575e00.pdf

Hill C. (2005) Making the Links: Addressing HIV/AIDS and Gender Equality in Food Security and Rural Livelihoods Programming, A toolkit to support CIDA staff working on initiatives related to food security and rural livelihoods
http://icad-cisd.com/pdf/publications/E_MakingtheLink_AIDS_AGRICULTURE2.pdf

International HIV/AIDS Alliance HIV/AIDS Fact Sheets
http://www.aidsalliance.org/custom_asp/publications/view.asp?publication_id=54

Oxfam (2007) Humanitarian Programmes and HIV and AIDS, A practical approach to mainstreaming
http://www.oxfam.org.uk/what_we_do/resources/downloads/Hum_Prog_HIV_AIDS.pdf

Swiss Agency for Development and Cooperation Mainstreaming HIV/AIDS in practice
http://www.deza.ch/ressources/resource_en_24553.pdf

UNDP and HAPCO (200?) A Handbook for HIV and AIDS Mainstreaming for a Scaled up Gender Sensitive Multisectoral Response, Addis Ababa: HAPCO

Welbourn A. (1995) Stepping Stones: A training package in HIV/AIDS, communication and relationship skills, Strategies for Hope (ActionAid)
http://www.steppingstonesfeedback.org/

Wiegers E with Scott M. (Ed) (2004) HIV/AIDS, Gender Inequality and the Agricultural Sector, Guidelines for Incorporating HIV/AIDS and Gender Considerations into Agricultural Programming in High Incidence Countries, Ottawa: Interagency Coalition on AIDS and Development
http://icad-cisd.com/pdf/publications/Gender_Inequality_Agriculture_FINAL.pdf

Annex 1: Example of Woreda HIV/AIDS Fact Sheet: Dale, SNNPR

በኢትዮጵያ ፌዴራላዊ ዴሞክራሲያዊ ሪፑብሊክ
የግብርናና ገጠር ልማት ሚኒስቴር
Federal Democratic Republic of Ethiopia
MINISTRY OF AGRICULTURE AND
RURAL DEVELOPMENT

Canadian International Development Agency | Agence canadienne de développement international

REGIONAL AND LOCAL HIV DATA (2005 estimates)

	Adult HIV prevalence rates (percentage of adults (aged 15 – 49) who are infected with HIV)		**Adult HIV incidence** (percentage of uninfected adults (aged 15 – 49) who become infected in each year)
	rural	urban	
Regional	1.5	10.2	0.18
National	1.9	10.5	0.26

Source: Ministry of Health/HAPCO (2005) *AIDS in Ethiopia, 6th Report*

HIV prevalence data from ante-natal clinics in or close to PLW (2005):

- *To north*: Awassa health centre 9.2%; Shashemene health centre 7.0%
- *To south*: Dilla hospital 9.3%

STAGE OF HIV/AIDS EPIDEMIC IN COMMUNITY

Towns: AIDS impacted (HIV prevalence rate and AIDS-related illnesses and deaths noted, high incidence of STDs).

Rural areas: AIDS impending (HIV prevalence rate high but not yet heavily impacted by AIDS related illnesses and deaths).

SOURCES OF INFECTION I: HIV-risky environments

Yirgalem, Dilla, Hantete: market centres (especially Dilla), busy towns, Fura training centre (Yirgalmen).

Other locations in woreda: small rural markets, coffee hulleries, grain mills, night open markets, night mass praying homes.

Outside woreda: Awassa (administrative centre), Shashemene (trading), Moyale (livestock, trading on Kenyan border), Shakiso (gold, coffee, livestock).

SOURCES OF INFECTION II: Bridging populations linking rural community to HIV-risky environments	
People from rural community moving to external environment: ***Long term***: students, male migrant workers (leave families for up to two years), traders, people seeking medical treatment, men pleasure-seeking, pastoralists (with herds in lowlands and highlands), women who have left their husbands. ***Seasonal***: students studying locally return home at weekends, migrant workers after coffee harvest for 2 – 6 months up to 2 years. ***Short (day) visits***: men to Awassa for business; people may spend several days in Dilla market; visitors to relatives for 2 – 3 weeks; women collecting water; church representatives; people accompanying sick for medical treatment. **Market-related movements within and beyond community**: ***Night markets***: often for socialising (not necessarily trading), return home in dark (may meet lovers but also risk for women). ***Queues at crop processing sites*** *(women and men)*: at grain mills, coffee hulleries: travel home at night. ***Traders/merchants*** *(men from community)*: stay in big towns (Chuko, Dilla, Aleta Wondo, Shashemene, Addis Ababa) in coffee season for 5 – 7 days for recreation, return with goods to sell. ***Petty traders*** *(women):* in grains, poultry, dairy products.	**People from external environment moving into rural community**: ***General***: BoA staff, DAs, teachers, health care workers, administrative workers, politicians, returnees to community (ex-politicians, ex-servicemen, people returning from abroad), relatives, transport service providers, merchants, commercial sex workers. ***Site specific***: road construction workers. **Market-related movements**: ***Casual labourers*** *(from region)*: on work large farms, at hulleries. ***Buyers***: stay for three months at coffee hulleries during harvest. ***Traders*** *(mostly men)*: stay overnight when buying coffee. ***Commercial sex workers***: stay in Yirgalem during coffee harvest.

SOURCES OF INFECTION III: Traditions and cultural practices in community which may result in contact with virus

Unprotected sex with infected person:

- chat chewing and alcohol consumption
- rape (not considered to be a crime)
- weddings and festivities (*fitche chanbalala* Sidama new year, annual *faro* dance and music for 11 – 15 year olds)
- religious night prayers and choir groups
- polygamy
- widow inheritance
- ability of divorced woman to remarry husband after she apologies regardless of whether he has married someone else
- reluctance to use condoms (taboo in rural areas)

Contact with contaminated body fluids:

- circumcision of men (*berchemiro*) aged over 40 years (followed by *hano* dance which may result in extra marital sex)

Mother to child transmission:

- pregnancy
- birth
- breast-feeding

EVIDENCE OF AIDS IMPACTS

Community response: HIV/AIDS awareness raising through schools, churches, other social gatherings and health posts but discrimination towards PLWHA and self exclusion by infected persons; community capacity enhancement used to encourage communities to discuss HIV/AIDS; generally community in stage of denial regarding presence of disease; decline in religious prayer groups at night; increase in use of condoms in towns; some requests for pre marriage HIV tests; reduction in sharing of same razor blade in rural areas.

Composition of community: reduction in polygamous households due to Christianity; increase in households headed by women (less polygamy, less widow inheritance, male migration, divorce) and single men; households headed by orphans and grandparents (always present because loss of parents to malaria) have also increased.

Change in livelihoods: land shortage in *woreda*, no fallow land and reduction in asset base due to high population pressure and effects of drought, rather than impact of AIDS.

Care for PLWHA and AIDS orphans: no specific care.

Change in burial traditions: reduction in number of days spent mourning (to two) because cannot afford to feed large number of mourners for more than a few days.

POTENTIAL VULNERABILITY TO FUTURE IMPACTS OF AIDS

Rich and middle wealth households: seek medical treatment during sickness, relatives provide assistance, raise money by selling cattle, coffee land. After some time, bereaved spouse will remarry. Rich households hire labour to cope with labour peaks; middle wealth households may use reciprocal labour and family labour (but have to feed them) or hire labour.

Poor households: treat patient at home, limited assistance from others, bereaved spouse will not remarry and may migrate; orphans will be supported by relatives or migrate. Survive by hiring out labour to other farmers, begging and receiving relief assistance.

Debt repayment: Sidama microfinance institution requires 1% of principal as insurance against the death of borrower but does not require family to repay loan; Omo microfinance institution has no insurance requirement but family members are responsible for loan repayment in event of death of borrower.

Women: 58% of total population.

OPPORTUNITIES

Actions (see separate checklist):

- Raising awareness and understanding about HIV/AIDS
- Reducing risk of exposure to HIV infection
- Reducing vulnerability to AIDS impacts

Potential partners:

- *Woreda* Agriculture Desk
- *Woreda* Women's Affairs office
- *Woreda* HAPCO
- women and youth associations
- anti-AIDS clubs
- religious institutions
- *Idirs* (burial societies)
- *Ersho* (association of PLWHA)
- 149 DAs and 25 FTCs
- health centres
- 12 multipurpose cooperatives (all members of Sidama Coffee Farmers' Cooperative Union); urban dairy cooperative plus others in process of registration
- private sector (pulpers/dehulllers)
- NGOs (Family Guidance Association of Ethiopia, Southern Branch) and CBOs
- VCT (Yirgalem)
- Sidama microfinance institution, Omo microfinance institution
- Sidama radio
- Fora Training Institute

Improving Productivity and Market Successes for Ethiopian Farmers Project
International Livestock Research Institute, PO Box 5689,
Addis Ababa, Ethiopia
Tel: 251 11 6172000; Fax: 251 11 6172001
www.ipms-ethiopia.org; www.ilri.org

2007